Department of the Army
Headquarters
United States Army Medical Department Activity
2480 Llewellyn Avenue
Fort George G. Meade, Maryland 20755-5800
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*** MEDDAC/DENTAC Regulation 40-17**

Medical Services

Sedation/Analgesia

FOR THE COMMANDER:

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History. This update is the third revision of this regulation, which was originally published on 5 January 1996.

Summary. This regulation covers responsibilities and procedures for administering sedation/ analgesia outside the operating room. This update of the regulation changes the title, which was formerly "Conscious Sedation," and throughout, changes all references to "conscious sedation" to read "sedation/analgesia."

Applicability. This regulation applies to the Headquarters, U.S. Army Medical Department Activity, Fort George G. Meade (MEDDAC), all outlying U.S. Army health clinics, and the Oral and Maxillofacial Surgery Service, Dental Clinic Number 3, U.S. Army Dental Activity, Fort George G. Meade.

Proponent. The proponent of this memorandum is the Chief, Anesthesia Service.

Supplementation. Supplementation of this publication is prohibited.

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* This update supersedes MEDDAC/DCC Regulation 40-17, dated 21 July 1999.

Suggested improvements. Users of this publication are invited to send comments and suggested improvements, by memorandum, directly to the Commander, U.S. Army Medical Department Activity, ATTN: MCXR-ZN-A, Fort George G. Meade, MD 20755-5800, or to the MEDDAC's Command Editor by fax to (301) 677-8088 or e-mail to john.schneider@na.amedd.army.mil.

Distribution. Distribution of this publication is by electronic medium only.

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Chapter 1
Introduction

1-1. Purpose
This regulation prescribes policies, procedures and responsibilities for the administration of sedative/analgesic medications outside the operating room (OR) at Kimbrough Ambulatory Care Center (KACC) and all outlying clinics within the MEDDAC.

1-2. References
Related publications are listed in appendix A. Referenced forms are also listed in appendix A.

1-3. Explanation of abbreviations
Abbreviations used in this regulation are explained in the glossary.

1-4. Responsibilities
a. *The Deputy Commander for Clinical Services (DCCS)*. The DCCS will—

(1) Approve all MEDDAC policies and procedures related to sedation/analgesia.

(2) Ensure compliance with this regulation.

b. *Chiefs of departments and services, and commanders/medical directors of outlying clinics, where sedation/analgesia is performed*. Chiefs of departments and services, and commanders/medical directors of outlying clinics, where sedation/analgesia is performed will—

(1) Ensure that the physician provider has completed the KACC Sedation/Analgesia Provider Course.

(2) Ensure that the nonphysician patient monitor has completed the KACC Sedation/Analgesia Patient Monitor Course.

(3) Maintain and annually review/update a standing operating procedure (SOP) that is consistent with this regulation and which includes a list of medications acceptable for use.

(4) Conduct quality improvement reviews at least monthly. Reviews will be regulated in accordance with (IAW) each section's Quality Improvement/Risk Management plan. MEDDAC Form 734 (Sedation/Analgesia Performance Improvement/Outcomes Survey Tool) will be used for this purpose. This form is included in the R-Forms section at the back of this publication and also on the MEDDAC web site.

c. The Chief, Anesthesia Service. The Chief, Anesthesia Service will—

(1) Monitor compliance of MEDDAC activities with regard to this regulation.

(2) Ensure that the standard of care described within this regulation is maintained throughout the MEDDAC.

(3) Approve the medications used for sedation/analgesia by each MEDDAC activity.

(4) Approve and update the content of the sedation/analgesia training program.

(5) Administer the posttest to both physician and nonphysician providers upon completion of their respective training programs.

d. The Chairperson, MEDDAC Pharmacy and Therapeutics Committee (P&TC). The Chairperson, P&TC will ensure that lists of medications to be used by each department, including any additions, are approved by the committee.

Chapter 2
General Information, and Guidelines

2-1. General information

a. Sedation/analgesia lies on a dose dependent continuum between the awake state and general anesthesia. The goal of sedation/analgesia is a calm, cooperative, patient that can respond purposefully to verbal commands, either alone or by light tactile stimulation. No interventions are necessary to assist the patient in maintaining a patent airway or spontaneous ventilation.

b. Standards for sedation and analgesia apply when patients receive, in settings outside the operating room, for any purpose, by any route, moderate or deep sedation/analgesia. Definitions of the four levels of sedation and anesthesia include the following (extracted from the CAMAC, TX-8, 2000-2001):

(1) *Minimal sedation* (anxiolysis). A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(2) *Moderate sedation/analgesia* ("conscious sedation"). A drug-induced depression of consciousness during which patients respond purposefully (i.e., reflex withdrawal from a painful stimulus is not considered a purposeful response) to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(3) *Deep sedation/analgesia*. A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(4) *Anesthesia*. Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

c. Patient response to sedative/analgesic medications can vary greatly. Small doses of these medications may rapidly produce loss of consciousness, loss of protective airway reflexes, and cessation of breathing. An essential requirement for a safe patient experience is the presence of an educated/certified vigilant team committed to the judicious use of these medications and complete adherence to the standards contained within this regulation.

2-2. Guidelines

a. Providers may download MEDDAC Form 720 (Pre-Anesthetic Assessment for Sedation/ Analgesia and Flowsheet) and MEDDAC Form Letter 208 (Informed Consent for Sedation/ Analgesia) from the KACC web site as needed. Complete them for all patients undergoing invasive procedures requiring the use of sedative/ analgesic medications. These forms are part of the patient's permanent medical record.

b. The back of MEDDAC Form 720; i.e., the flowsheet side, will be used to document the patient's vital signs, medications administered, sedation score, and readiness for discharge.

c. Prior to performing procedures requiring sedation/analgesia, the LIP must be specifically trained and credentialed in sedation/analgesia. The LIPs may take the KACC provider course available at http://www.narmc.amedd.army.mil/kacc/ or they can provide evidence of successful completion of a provider course. Evidence of this certification will be kept in the provider's credentialing file. The LIP will maintain current Advanced Cardiac Life Support certification (ACLS).

d. Prior to performing the invasive procedure, the physician provider must thoroughly assess each patient to ensure that the appropriate support services are available at each clinic location in the event a medical complication occurs during or after the procedure. Patients with severe systemic diseases such as chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, morbid obesity, sleep apnea, or known difficult airways, may not be appropriate candidates for invasive procedures in the clinic setting. These patients should have their procedures performed at a medical treatment facility that possesses the necessary support systems.

e. A member of the anesthesia staff will provide sedation/monitoring for all pediatric patients under 5 years of age. Procedures on patients under 5 years of age will be performed in the operating room, unless the procedure requires a special location or equipment (e.g., radiology).

f. Procedures requiring sedative/analgesic medications must have the following personnel present: the LIP performing the procedure, a person assisting the LIP with the procedure, and a dedicated patient monitor.

g. The patient monitor will remain with the patient throughout the procedure. This provider will not participate in the procedure.

h. Minimum qualifications for the patient monitor include basic life support certification and successful completion of the KACC Sedation/Analgesia Patient Monitor Course. (See chapter 3, below.) ACLS certification is strongly encouraged.

i. When the patient monitor is other than a CRNA or other LIP, the LIP performing the procedure is completely responsible for ensuring that—

(1) The patient is continually monitored.

(2) The patient's vital signs are within normal limits and that they are recorded IAW SOP.

(3) The patient is recovered and discharged IAW established protocol.

j. A physician, oral surgeon or CRNA will be responsible for ordering the sedative/ analgesic medications.

k. Only the LIP, CRNA or qualified registered nurse (RN) will handle and administer the medications.

l. The following agents are approved for use during sedation/analgesia procedures:

(1) Demerol.

(2) Morphine.

(3) Fentanyl.

(4) Midazolam.

(5) Diazepam

m. Patients must be NPO for a minimum of 6 hours prior to the procedure.

n. An intravenous line will be established prior to the start of the procedure.

o. All patients will receive supplemental oxygen during the procedure.

p. Blood pressure, pulse, and respirations will be recorded at least every 5 minutes during the procedure. See appendix A for an example of the intraprocedure form.

q. Oxygen saturation (SaO_2) and the electrocardiogram will be monitored continuously. SaO_2 readings will be recorded at least every 15 minutes during the procedure. All significant decreases in SaO_2 (greater than a 5 percentage point decrease from baseline) will be documented along with the duration of the decrease.

r. Patient emotional affect, level of consciousness, vital signs, and physical reaction to the procedure (Clark Conscious Sedation Scale), will be monitored throughout and documented every 15 minutes.

s. When practical, patients will be monitored post-procedure in the Post-anesthesia Care Unit (PACU). When patients are recovered elsewhere, the same PACU standard of care must be met. The PACU recovery protocol will be used, including the Aldrete scoring system.

t. Patients must be discharged either by an LIP or by the rigorous application of discharge criteria by the RN. The patient's readiness for discharge will be documented on his or her record.

u. The patient must be discharged in the care of a responsible adult. Verbal and written instructions not to drive, operate hazardous machinery or drink alcohol for 24 hours will also be provided and documented.

Chapter 3
The KACC Sedation/Analgesia Patient Monitor Course

3-1. Target attendees

The KACC Sedation/Analgesia Patient Monitor Course is designed for KACC and DENTAC health care providers who care for patients undergoing invasive procedures under sedation and or analgesia.

3-2. Course administration and format

The KACC Sedation/Analgesia Patient Monitor Course is a self-paced, internet-based course. Students may access the site at http://www.narmc.amedd.army.mil/kacc/. Upon completion, students must print the answer sheet found at the end of the course and submit it, completed, to the Chief, Anesthesia Service for evaluation. A passing score is 80%. If unable to complete the course in this modality, a companion videotape and course handout is available from the Anesthesia Service. Students may then view the tape, read the handout and take the posttest.

3-3. Clinical experience

a. *Gastroenterology experience*.

(1) Students will coordinate their clinical experience with the head nurse of the gastroenterology clinic.

(2) The head nurse will schedule the students based on the clinic's patient load.

(3) The main objectives are to orient to the physical plant, patient flow, the monitors, sedation technique, and the documentation required.

b. *OR experience*.

(1) If required, students can be scheduled to spend time in the operating room with a

CRNA. The students will be provided an opportunity to observe patients that have been given sedative and or analgesic medications. Scheduling must be coordinated with the Chief, Anesthesia Service.

c. *Certification and recertification*.

(1) MEDDAC Form 735 (Sedation/Analgesia Patient Monitoring Competency-based Orientation) may be copied or printed from the R-Forms section at the back of this publication or from the MEDDAC's web site. The nurse manager of the gastroenterology service will fill out the form for each patient monitor on an annual basis. The forms will be filed and maintained by the gastroenterology nurse manager.

(2) Recertification is annual and is granted by the head nurse of the gastroenterology clinic. Recertification is based on the competency based sedation/analgesia checklist and the actual performance of providing sedation/analgesia for patients undergoing invasive procedures during the past year.

3-4. Course references

Course references are listed in appendix B.

Appendix A
References

Section I
Required Publications

This section contains no entries.

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

AR 310-50
Authorized Abbreviations, Brevity Codes, and Acronyms

MEDDAC Reg 40-24
Code Blue. (Pertains only to KACC and Dental Clinic No. 3.)

Local (Outlying Clinic) Code Blue policies. (Pertains only to outlying clinics.)

Note: Other related publications are listed in appendix B.

Section III
Prescribed Forms

MEDDAC Form 720
Pre-Anesthetic Assessment for Sedation/Analgesia and Flowsheet. (Prescribed in para 2-2.)

MEDDAC Form 734
Sedation/Analgesia Performance Improvement/ Outcomes Survey Tool. (Prescribed in para 1-4.)

MEDDAC Form 735
Sedation/Analgesia Patient Monitoring Competency-based Orientation. (Prescribed in para 3-3.)

MEDDAC Form Letter 208
Informed Consent for Sedation/Analgesia. (Prescribed in para 2-2.)

Section IV
Referenced Forms

This section contains no entries.

Appendix B
Course References

American Association of Nurse Anesthetists (June, 1996). Qualified Providers of Conscious Sedation. The Association, Park Ridge, IL, 2.2.

American Medical Association Council on Scientific Affairs (1993). The Use of Pulse Oximetry During Conscious Sedation. Journal of the American Medical Association, 270 (12), 1463-1467.

American Society of Anesthesiologists (June, 1995). Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. The Society, Park Ridge, IL.

Barash, P.G., Cullen, B.F. & Stoelting, R.K. (Eds.) (1992) Clinical Anesthesiology. (2nd ed.). Philadelphia, PA: J.B. Lippincott Co.

Barnhart, E.R. (pubr.) (1990) Physicians' Desk Reference. (44th ed.) Oradell, N.J.: Medical Economics Co. Inc.

Grauer, K. & Cavallaro, D. (1993). ACLS Certification Preparation. (3rd ed.). St. Louis, MO: Mosby Lifeline.

Holzman, R.S., Cullen, D.J., Eichhorn, J.H., & Philip, J.H. (1994). Guidelines for Sedation by Nonanesthesiologists during diagnostic and Therapeutic Procedures. Journal of Clinical Anesthesia, 6, 265-276.

Iber, F.L., Sutberry, M., Gupta, R., and Kruss, D. (1993). Evaluation of complications during and after conscious sedation for endoscopy using pulse oximetry. Gastrointestinal Endoscopy, 39 (5), 620-625.

Joint Commission on Accreditation of Healthcare Organizations (2001). Comprehensive Accreditation Manual for Ambulatory Care (January 1, 2001), pp. TX-3 through TX-12. JCAHO, Oakbrook Terrace, IL 60181.

Kost, M. (1998) Manual of Conscious Sedation. Philadelphia, PA: WB Saunders.

Morgan, E.G. & Mikhail, M.S. (1996) Clinical Anesthesiology. (2nd ed.) Stamford, CT: Appleton & Lange.

Appendix C
Course Objectives

C-1. Identify with 100% accuracy the state of sedation (light sedation, deep sedation or general anesthesia) by assessing eye movement, respirations, protective reflexes and level of consciousness.

C-2. Classify without error the commonly used pharmacological agents according to their action (anxiolytic, sedative-hypnotic or analgesic) and chemical class (benzodiazepine, barbiturate, antihistamine or opioid).

C-3. Select from a list situations for which the sedation/analgesia protocol is not intended.

C-4. List situations requiring consultation with anesthesia before providing sedation/analgesia.

C-5. Identify from a list competency requirements related to the provision of sedation/analgesia.

C-6. List monitoring parameters that must be recorded every 5 minutes during the procedure.

C-7. Given orders for sedation/analgesia, demonstrate correct administration including titrating to effect.

C-8. Identify discharge parameters including level of consciousness, vital signs, time since reversal agent and patient/family education.

C-9. List common complications arising from administration of sedation/analgesia medications and recognize which is most common.

C-10. Correctly handle complications occurring during sedation/analgesia scenarios.

C-11. Identify legal implications involving sedation/analgesia.

Glossary

Section I
Abbreviations

AANA
American Association of Nurse Anesthetists

ACLS
advanced cardiac life support

CBO
competency based objectives

CRNA
certified registered nurse anesthetist

DCCS
Deputy Commander for Clinic Services

DENTAC
U.S. Army Dental Activity, Fort George G. Meade

ECG
electrocardiogram

IV
intravenous

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

KACC
Kimbrough Ambulatory Care Center

LIP
licensed independent practitioner

MEDDAC
U.S. Army Medical Department Activity, Fort George G. Meade

NPO
nothing by mouth (also nothing per mouth)

OR
operating room

PACU
post-anesthesia care unit

P&TC
Pharmacy and Therapeutics Committee

PTM&S
Plans, Training, Mobilization and Security Division

RN
registered nurse

SaO_2
oxygen saturation

SF
standard form

SOP
standing operating procedure

Section II
Terms

This section contains no entries.

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(See DD Form 2005 for Privacy Act Statement)

PRE-ANESTHESIA ASSESSMENT FOR SEDATION/ANALGESIA AND FLOWSHEET

HISTORY

Pertinent history, chief complaint and condition of admission

☐ Alert and oriented X 3 ☐ Other:

Impression:

Plan: FFS, EGD, colonoscopy

Social History: Tobacco | Alcohol | Drugs

Allergies:

Current medications* ☐ None

OTC: _____

Dietary/herbal: _____

* Coumadin, ASA and insulin patients require pre-procedure instructions.

PHYSICAL EXAMINATION

Pulse	BP	Resp	Temp	Pain (0-10)	Age	Height	Weight

Oropharynx	Heart	Pulmonary	Abdomen	OB/GYN
Dental: ☐ Partial ☐ Edentulous Mallampati Classification:	Heart rate: ☐ Regular rate and rhythm ☐ Irregular ☐ Murmur	Breath sounds: ☐ Clear ☐ Rales ☐ Rhonchi ☐ Wheezes	☐ Soft ☐ Tender ☐ Masses	LMP:

Anesthesia plan
☐ Sedation/analgesia
☐ No medication anticipated

Reason for choice of anesthesia
☐ Patient's choice
☐ Anxiety control
☐ Pain control

Premedication ☐ None

ASA classification:
☐ I ☐ II ☐ III

Required pre-procedure testing
☐ None ☐ HCG ☐ EKG ☐ CXR PA/LAT
☐ Labs: _____

☐ Other: _____

Informed consent Reviewed and signed? ☐ Yes ☐ No

Pre-procedure orders

Admit for: o Colonoscopy o EGD o FFS o Other:

1. Vital signs on admission.
2. IV start with 1000 NS@KVO
3. Oxygen @ 2L via nasal cannula during procedure
4. Cardiac, oxygen saturation, vital signs monitoring during procedure
5. Medications: o Demerol - 100 mg IV
   o Versed - 4 mg IV
   Other: mg IV

Provider's printed name or stamp	Signature	Date

IMMEDIATE PRE-PROCEDURE ASSESSMENT

Pulse	BP	Resp	Temp	Oxygen sat	Pain (0-10)

Did the patient take required premedication?
☐ Yes ☐ No ☐ N/A

Interval changes since preanesthetic assessment ☐ No ☐ Yes *(If "Yes," explain.)*

Abdomen upon palpatation:
☐ Soft ☐ Tender ☐ Firm ☐ Distended

Patient has been NPO hours.

Are there any modifications to the anesthetic or procedure plans? ☐ Yes ☐ No

Removed-
Contact lenses ☐ Yes ☐ No ☐ N/A
Dentures ☐ Yes ☐ No ☐ N/A

X-ray, EKG and Lab Data (if ordered)

Test	Date	Result	Test	Date	Result
HCG					
EKG					

Printed name of person completing this assessment	Signature	Date	Time

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility; SSN)*

SEDATION/ANALGESIA FLOWSHEET

Date	Unit	Procedure ☐ Colon ☐ EGD	MD	RN	GI Tech	Consent: ☐ Yes ☐ No

Allergies	**IV START** Time: Site: Size:	**IV FLUIDS** Time:			Totals infused
Scope Serial No.	**IV DISCONTINUED** Time: Condition:	Type:			
		NPO since:	Prep: ☐ Phospha Soda ☐ Colyte		

EQUIPMENT CHECKED
☐ Yes ☐ No

LEGEND:
v = Systolic BP
^ = Diastotic BP
● = Pulse
* = See comments
= Negative or Not Reassessed

Cautery type:
Ground pad: ☐ Yes ☐ No
Site:
Dilation type:
Specimens:

Time																							
220																							
210																							
200																							
190																							
180																							
170																							
160																							
150																							
140																							
130																							
120																							
110																							
100																							
90																							
80																							
70																							
60																							
50																							
40																							
Resp																							
SaO_2																							

ECG: 1. NSR 2. Consistent w/baseline 3: Other
O2 Appliance: 1. Cannula 2. Mask @ _____ liter/minute

SEDATION ANALGESIA SCALE

Emotional affect:	2. Calm / Tolerant 1. Anxious / Uneasy 0. Unresponsive / Flat																			
LOC:	2. Follows commands / Intermittant arousal 1. Alert and awake 0. Unresponsive																			
Vital signs	2. Within acceptable limits 1. Increase, requires intervention 0. Decrease, requires intervention																			
Physical level of comfort:	3. Comfortable 2. Mild discomfort 1. Moderate discomfort 0. Severe discomfort																			
Total sedation scale (Optimal is 9):																				

MEDICATIONS

Route	Drug	Increment	Dosage																	

POST-OP ORDERS

1. Transfer to PACU via w/c until discharge criteria met; then to SDS via w/c.
2. Vital signs per protocol.
3. BRP with assistance.
4. NPO until:
   a. alert,
   b. passing flatus post-colonosopy, and or
   c. swallowing w/o difficulty post EGD; then discontinue IV when stable.
5. Discharge when stable and discharge criteria is met.

POST-ANESTHESIA SCORE

Score	Criteria	AD	15/M	
2	Able to move 4 extremities			
1	Able to move 2 extremities			
0	Able to move 0 extremities			
2	Able to breathe deeply and cough freely			
1	Limited breathing			
0	Apnea			
2	BP ± 20% of pre-anesthetic level			
1	BP ± 20%-50% of pre-anesthetic level			
0	BP ± 50% of pre-anesthetic level			
2	Fully awake			
1	Arousable on calling			
0	Not responding			
2	Normal			
1	Pale, dusky, blotchy, jaundiced			
0	Cyanatic			
	TOTAL SCORE:			

PROC START/END TIMES

Started:	Ended:

TRANSFER TIMES

To PACU:	To SDS:

DISCHARGE
LOC:
☐ Awake ☐ Drowsy
☐ Consistent with baseline
☐ Other:

PROCEDURE RECALL
0. Total
1. Limited Score: _____
2. No recall

DISCHARGE CRITERIA
☐ Ambulatory/steady gait
☐ Ambulatory/min. support
☐ Wheelchair ☐ Cart
☐ Min. or no nausea/vomiting
Abdomen ☐ Soft ☐ Distended
☐ Passed flatus

DISCHARGE
Time: _____
Accompanied by:
☐ Relative
☐ Friend
☐ Other: _____
Destination:
☐ Home
☐ Other: _____

DISCHARGE INSTRUCTIONS
Reviewed. Understanding was verbalized. Printed information given:
☐ Yes ☐ N/A Initials:

Printed name of person completing this assessment	Signature	Date	Time

SEDATION/ANALGESIA PERFORMANCE IMPROVEMENT/OUTCOMES SURVEY TOOL

1. Patient's initials and last 4 of SSN	2. Date of procedure	3. Date of chart review	4. Doctor	5. Procedure ☐ Colon ☐ EGD ☐ FS ☐ Oral surgery

6. Biopsies? ☐ Yes ☐ No 7. Polypectomy? ☐ Yes ☐ No	8. Medication given ☐ Demerol _____ mg ☐ Versed _____ mg ☐ Fentanyl _____ mg ☐ Other: _____

9. Nurses

a. Admitting:	b. Procedure:	c. PACU:	d. Recovery:

10. Indicator checklist

Indicator	Y	N	Comments
a. Indication for procedure on chart.			
b. Updated H&P on chart (within 30 days of procedure), ASA classification, list of patient's current medications; airway and mental status.			
c. Procedure nurse evaluation of patient prior to procedure.			
d. Provider's, patient's and witness's signatures present on consent and discharge instructions.			
e. Charting of medications administered and vital signs (to include pain) documented per protocol.			
f. Equipment available peer protocol: SAO2/EKG/BP monitor, suction, ambu bag, etc.			
g. Complete description of procedure with post-procedure impressions included.			
h. Completion of post-anesthesia flow sheet.			
i. Absence of drug reversal agent use (for example, Narcan and Romazicon) or other medications (Atropine, etc.).			
j. Use of mechanical ventilation or manual airway support.			
k. Decrease of O2 saturation below 90% for 5 minutes or longer; or below 80% any time during the procedure.			
l. 30% change in the admission baseline in HR/BP and or the occurrence of atrial or ventricular arrhythmia.			
m. Development of CNS complications, loss of consciousness, peripheral neurological deficit, MI, cardiac arrest or death.			
n. Unplanned transfer via stretcher, admission to hospital, or increase in the level of care required.			
o. Equipment problems encountered during the procedure.			
p. Discharge criteria met or MD notified of problem.			
q. Follow up phone call initiated and documented.			

MEDDAC (Ft Meade) Form 734, 1 Nov 01

SEDATION/ANALGESIA PATIENT MONITORING COMPETENCY-BASED ORIENTATION

Name *(Last, First, MI)*	Rank or grade	Position	Unit

The perceptor or supervisor of the individual identified above will complete this form. The individual will review the requirements and indicate whether he or she is proficient or needs review by placing a check mark in the appropriate column for each item listed below ("P" = proficient, "N" = needs review). The preceptor or supervisor will evaluate the individual's competence either by observation of direct patient care or return demonstration in a skills lab. In completing this form, the individual identified above demonstrated knowledge and ability to perform the following skills and procedures at least once annually.

N	P	SKILLS AND PROCEDURES	INITIALS	DATE
		PREREQUISITES:		
		Certified in sedation/analgesia. (Has completed a course.)		
		Reviews MEDDAC Reg 40-17, Sedation/Analgesia, and the Gastroenterology IV Sedation Policy		
		Oriented to GI Procedure Room		
		ASSESSMENT:		
		Reviews patient's medical chart for the following documentation:		
		History and physical		
		Labs, EKG and or chest x-rays		
		Medications ordered		
		Informed consent		
		Performs baseline assessment, to include the following:		
		VS with O2 saturation level		
		Allergies		
		NPO status and prep completion		
		IV patency and IV fluids noted		
		Cardiac monitoring		
		Significant medical history		
		PLANNING:		
		Establishes patient's ID, escorts patient with medical chart and ordered medications from Same Day Surgery (SDS) to Gastro Procedure Room		
		Plans for equipment, including monitoring and resuscitation		
		Plans for medication administration, including IV Push and reversal agents		
		Confirms patent IV		
		IMPLEMENTATION:		
		Monitors cardiac rhythm, VS including O2 saturation level, every 5 minutes beginning with medication administration and for 10 minutes after procedure is completed		
		Administers medication per physician orders and IV Push guidelines		
		Notifies physician of patient's progress, abnormal variations in VS and patient's response		
		EVALUATION:		
		Evaluates patient response to IV sedative/analgesic medications and to the GI procedure		
		Determines patient readiness for discharge and mode of transport to the Post-anesthesia Care Unit (PACU)		
		Calls report to the PACU nurse with appropriate information for transfer		
		Escorts patient, via wheelchair, olympus chair/couch, or litter with medical chart to the PACU		
		Returns unopened and unused medication to SDS and disposes of leftover medications IAW KACC policy		

Comments: (Total hours for this candidate to complete procedure, etc.

Name of Preceptor:

	Date	Results	Verified
Annual review of competence:			

MEDDAC (Ft Meade) Form 735, 1 Nov 01

INFORMED CONSENT FOR SEDATION/ANALGESIA

I, _____ , understand that I am to undergo a medical procedure that may require sedation.

I have been informed that the primary goal of sedation is to relieve fear and anxiety while still being able to cooperate with the procedure. Adverse and or undesirable effects may include slurred speech, unarousable sleep, low blood pressure, anxiety, combativeness, decreased respirations, respiratory depression, airway obstruction, and, in rare instances, cardiac arrest.

I have also been informed that all sedative drugs, including anesthetic agents, may slow my reaction time, and, although I may think my reactions are normal, they will be affected. I have been told not to drive or operate vehicles or machinery for 24 hours and that I will need someone to drive me home following the procedure. I have been informed not to drink alcohol, make critical decisions or sign any legal documents until the day after the procedure.

My signature below signifies my awareness--

a. That I have read, or have had read to me, and agree to all of the above.

b. That the information has been satisfactorily explained to me in terms that I understand.

c. That I understand all that I have read and or had explained to me and that I have all the information I desire concerning the forthcoming medical procedure.

d. That I have been given the opportunity to ask any questions that I might have concerning sedation.

e. That I have signed this form prior to receiving sedation.

f. That I hereby give my authorization and consent.

Patient's or legal representative's printed name	Patient's or legal representative's signature	
Relationship to patient *(If other than patient.)*	Date	Time
Witness's printed name	Witness's signature	
Provider's/registered nurse's printed name or stamp	Provider's/registered nurse's signature	